REQUEST FOR TUBERCULOSIS STATEMENT

To: Physician/Health Department **Date:** _____

From: _____
Local Department of Social Services

_____
Address

_____

_____
Agency Representative

Standards for local agency approved providers of care for clients require that the individual identified below obtain a statement that he/she is believed to be free from tuberculosis in a communicable form.

Name: _____

Address: _____

_____

Type of Care Provided: _____

This section is to be completed by a physician for provider named above.

Date of Test: _____

Type of Test: _____

Is this person believed to be free from tuberculosis in a communicable form? Yes ☐
No ☐

Physician's Signature: _____ **Date:** _____

Name of Physician: _____
(Print or Type)

Address: _____

_____

_____
Telephone

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